BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **KING T. LEUNG, M.D** Holder of License No. **10262** For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-05-0416A** **MD-06-0340A** **INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR SUMMARY SUSPENSION OF LICENSE**

INTRODUCTION

The above-captioned matter came on for discussion before the Arizona Medical Board ("Board") on November 30, 2006. After reviewing relevant information and deliberating, the Board considered proceedings for a summary action against the license of King T. Leung, M.D. ("Respondent"). Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License, pending formal hearing or other Board action. A.R.S. § 32-1451(D).

INTERIM FINDINGS OF FACT

1. The Board is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 10262 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0416A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a sixty year-old female patient ("RR"). RR presented to Respondent on January 26, 1998 complaining of rectal bleeding. Respondent performed a sigmoidoscopy and rectal examination and noted as his only finding internal hemorrhoids. There was no indication in the record there was retroflexion of the sigmoidoscope. Respondent noted the rectal examination was negative.

4. RR returned to Respondent in August 1999 complaining of recurrent rectal bleeding. Respondent performed a sigmoidoscopy and rectal examination. There was no indication in the record there was retroflexion of the sigmoidoscope. Respondent did not report any findings. RR returned to Respondent in April 2000 with abdominal distention and lack of bowel movement. Respondent performed a rectal examination that revealed an empty vault. Respondent admitted RR to the hospital. A computed tomography scan of the abdomen demonstrated a possible adrenal mass. A barium enema was negative for an obstructing lesion. RR was discharged to Respondent for outpatient follow-up. On May 10, 2000 Respondent referred RR to a colorectal surgeon for a May 25, 2000 appointment, but RR did not keep the appointment.

5. On May 12, 2000 RR presented to the emergency room where another physician performed a rectal examination that showed a trace of blood and no palpable rectal mass. In September 2000 RR underwent resection of a large rectal carcinoma. RR later developed metastasis and died.

6. The standard of care in evaluating recurrent rectal bleeding requires a physician to look above the reach of the sigmoidoscope using retroflexion. The standard of care also requires a physician to timely refer the patient for a more comprehensive evaluation by a subspecialist.

7. Respondent deviated from the standard of care because he did not look above the reach of the sigmoidoscope using retroflexion and because he did not timely refer RR for a more comprehensive evaluation by a subspecialist.

8. Respondent's failure to look above the reach of the sigmoidoscope using retroflexion and failure to timely refer RR to a subspecialist resulted in his missing a rectal lesion and this delay in diagnosis and treatment led to RR's death.

9. The Board initiated case number MD-06-0340A after receiving a complaint regarding Respondent's care and treatment of a seventy year-old female patient ("FA"). The

Board's Chief Medical Consultant reviewed the complaint and asked Staff to obtain additional random charts for review.

10. FA was seen by Respondent nine times between January 16, 2006 and April 11, 2006. FA's initial complaint was pulmonary embolism, but Respondent's chart is not clear about what was actually happening with FA. Respondent was attempting to manage warfarin anticoagulation and there was a mention of thrombocytopenia, but Respondent did not note any differential nor was there any discussion in his records.

11. On January 30, 2006 FA had a sub-therapeutic Pro Time International Normalized Ratio ("PT/INR") that Respondent did not address. On February 8, 2006 Respondent diagnosed FA with polyarterities, but did not provide any explanation of this diagnosis and failed to address the sub-therapeutic INR. On March 1, 2006 Respondent gave FA Celebrex even though she was on warfarin and had thrombocytopenia. On March 3, 2006 FA presented to Respondent with diarrhea and Respondent diagnosed food poisoning. Respondent treated FA with clindamycin – not a known treatment for food poisoning. FA developed a rash and Respondent changed the medication to tetracycline – also not a known treatment for food poisoning. Respondent still did not attend to FA's anti-coagulation issues.

12. On March 6, 2006 Respondent diagnosed FA with colitis, but did not document any supporting discussion or evidence. Respondent also continued to fail to address FA's anti-coagulation issues. Respondent failed to perform an electrolyte evaluation and a complete blood count. FA returned to Respondent on March 15, 2006 apparently feeling better, but Respondent's chart contains limited documentation and no discussion of anti-coagulation. FA had a follow-up appointment with Respondent on March 20, 2006 and he recorded her INR at 6.9 and continued Coumadin at a reduced dose. Respondent did not mention holding the dose, but did mention FA's blood pressure was a problem. However, Respondent failed to record a blood pressure reading to support this finding. FA saw Respondent on April 11, 2006 for a follow-up appointment for

hypertension and Respondent diagnosed dysuria without a description or work-up. Respondent also diagnosed pulmonary infarction and thrombocytopenia with no discussion.

13. The standard of care requires a physician to administer Heparin until the patient is adequately anti-coagulated with Coumadin and to hold Coumadin when the patient's level is 6.9.

14. Respondent deviated from the standard of care by failing to administer Heparin to FA until she was adequately anti-coagulated with Coumadin and by failing to hold FA's Coumadin when her level was 6.9.

15. Poorly managed Coumadin in the setting of pulmonary embolism and inadequate treatment of dehydration caused by food poisoning could have caused permanent damage to FA's lungs, brain, kidney, and liver and could have resulted in her death.

16. Based upon the Medical Consultant's review of the case involving FA, Board Staff randomly selected two more patient charts for review.

17. Respondent provided care to a seventy-one year-old male patient ("MCM") from May 2000 until June 2006. MCM had hypertension and prostate cancer that was diagnosed in 1997 and treated with Lupron and seed implants. Respondent's progress notes were in a pre-printed format with areas to write in the chief complaint, history, physical examination, diagnosis/management options and plan. Respondent's notations for each visit with MCM were few – the entire history noted on the first visit is "c/o regular visit/PSA. I. Hypertension II. Prostate CA III. Hyperlipidemia." On subsequent visits MCM had hemoccult positive stools and elevated liver functions that Respondent failed to address with colonoscopy or barium enema with flexible sigmoidoscopy. Respondent ignored MCM's health maintenance issues and inadequately managed his hypertension.

18. The standard of care requires a physician to perform routine health maintenance, such as rectal examinations; to adequately work-up rectal bleeding by performing a colonoscopy or

barium enema with a flexible sigmoidoscopy; and to perform routine prostate examinations in patients with prostate carcinoma.

19. Respondent deviated from the standard of care because he failed to provide MCM with routine health maintenance, including rectal examinations; because he failed to adequately work-up MCM's hemoccult positive stool or bleeding; and because he failed to perform routine prostate examinations of MCM.

20. Inadequate health maintenance could delay a diagnosis of colon or prostate cancer.

21. KS, a fifty-five year-old male with coronary artery disease and a history of rectal bleeding, presented to Respondent complaining of acute severe headache. Respondent did not perform and/or document a neurologic examination of KS. Respondent diagnosed KS with migraines and treated him with a variety of medications. Respondent saw KS in follow-up of migraine and polyuria and polydipsia. Respondent did not perform a prostate examination, yet he diagnosed KS with prostatic enlargement.

22. KS saw Respondent multiple times for migraine and depression from June 2003 through February 2004. On February 5, 2005 Respondent diagnosed KS with attention deficit disorder and referred KS to a psychiatrist. At a May 18, 2006 visit Respondent noted KS had abnormal eye movements and on June 23, 2006 saw him for pre-operative clearance for eye surgery. Respondent noted an abnormal EKG and requested a cardiology consultation. KS was hospitalized from July 11, 2006 through July 15, 2006 by another physician who believed he had sustained a reversible ischemic neurologic deficit. During his hospitalization KS was noted to be aspirating and required PEG tube placement. Respondent saw KS on August 2, 2006, again to clear him for eye surgery. Respondent did not document KS's recent hospitalization or need for treatment of elevated cholesterol and tight control of blood pressure as recommended in a neurology consult obtained during KS's hospitalization. KS went on to have a stroke and hemiplegia.

23. The standard of care requires a physician to perform routine health maintenance; to perform a colonoscopy in a patient who presents with a history of rectal bleeding; to treat a patient's elevated cholesterol; and to control a patient's blood pressure.

24. Respondent deviated from the standard of care by failing to perform routine health maintenance, such as hemoccult testing for KS; by failing to work-up hemoccult positive stool or rectal bleeding; by failing to treat KS's elevated cholesterol; and by failing to control KS's blood pressure.

25. KS had a neurologic episode in July 2006 that may have been prevented if his blood pressure and cholesterol had been tightly controlled.

26. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records for all three patients were inadequate as described above.

27. During the review of case number MD-06-0340A a concern was raised about Respondent's ability to safely engage in the practice of medicine. In order to assess Respondent's competency the Executive Director, on October 26, 2006, issued an Interim Order requiring Respondent to present for an evaluation at the Physician Assessment and Clinical Education Program ("PACE") within thirty days of the date of the Order. Respondent was due to present to PACE no later than November 26, 2006. On November 27, 2006 PACE notified Board Staff that Respondent had informed them he would not be participating in the evaluation.

28. The Board Staff has now been informed that Respondent is or may be physically unable to safely engage in the practice of medicine due to serious health concerns.

29. The facts as presented demonstrate that the public health, safety or welfare imperatively requires emergency action.

INTERIM CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent, holder of License No. 10262 for the practice of allopathic medicine in the State of Arizona.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health or the patient or the public"); 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter"); 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient"); and A.R.S. § 32-1451(A) ("[p]hysically unable to safely engage in the practice of medicine").

3. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public health, safety or welfare imperatively requires emergency action. A.R.S. § 32-1451(D).

ORDER

Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above, IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice allopathic medicine in the State of Arizona, License No. 10262, is summarily suspended pending a formal hearing before an Administrative Law Judge from the Office of Administrative Hearings.

2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him.

Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this order.

3. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced as expeditiously as possible from the date of the issuance of this order, unless stipulated and agreed otherwise by Respondent.

DATED this 30th day of November 2006

[SEAL]

ARIZONA MEDICAL BOARD

By _____
Timothy C. Miller, J.D.
Executive Director

ORIGINAL of the foregoing filed this 30 day of November 2006, with:

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